EXHIBIT Q
CERTIFICATION OF COMPLIANCE WITH NEW JERSEY INDIVIDUAL HEALTH BENEFITS PLANS

In accordance with N.J.A.C. 11:20-3.2 submit this form before marketing or issuing any of the standard plans, and by March 1 of every year thereafter. Submit this form to the IHC Board at the following address: 20 West State Street, PO Box-325, Trenton, New Jersey 08625. Affiliated carriers must file separate forms. Carriers must complete the certification as set forth in this Exhibit; the words in the Certification may not be altered.

1. INFORMATION ABOUT THE CARRIER AND RESPONDENT

Carrier Name:
_____
NAIC #: _____
Respondent's Name:
_____
Respondent's Title:
_____
Respondent's Address:
_____
Respondent's Telephone _____ FAX
_____

2. COMPLIANCE

Check all appropriate responses.

_____ (a) We are using the following forms which fully comply with the IHC Board's individual health benefits plan forms and Explanation of Brackets (Exhibit T) as set forth in the appropriate Exhibit of the Appendix to N.J.A.C. 11:20:

- _____ Plan A Exhibit A
- _____ Plan A/50 Exhibit U
- _____ Plan B Exhibit B
- _____ Plan C Exhibit C
- _____ Plan D Exhibit D
- _____ Plan E Exhibit E
- _____ HMO Plan Exhibit F

_____ (b) Our application form complies with the IHC Board's form as set forth in Exhibit G and Explanation of Brackets (Exhibit T) in the Appendix to N.J.A.C. 11:20. Is the optional pre-existing conditions statement being included? _____ Yes _____ No

3. PLAN OPTIONS

Complete each relevant section (Please use "NA" to indicate when a section is not relevant.) Attach additional pages as necessary.

(a) Plans A/50 and A - E (To be completed by non-HMO carriers)

(1) Identify the standard plans to be offered as traditional indemnity contracts, if any.

Plan A*: ____ Plan A/50: ____ Plan B: ____ Plan C ____ Plan D: ____ Plan E* ____
*As of September 1, 1997, Plan A is available only for renewals of inforce Plan A business. As of November 1, 1998, Plan E is available only for renewals of inforce Plan E business.

(2) List all plans to be offered in conjunction with a selective contracting arrangement **(defined at N.J.A.C. 11:4-37)

PPO Plans:
Plan B: _____ Plan C _____ Plan D: _____ Plan E _____
POS Plans:
Plan C _____ Plan D: _____ Plan E _____
** A carrier must first have received approval of its selective contracting arrangement from the Departments of Health and Senior Services and Banking and Insurance before it may issue the standard individual plans through such arrangement. Note: Health Service Corporations are not subject to the statute and regulations relating to selective contracting arrangements. Such carriers should note the plans they are offering as if they were subject to selective contracting arrangements.

(3) For all plans to be offered in conjunction with a selective contracting arrangement, specify the network and out network coinsurance levels in the space provided next to the plan (Ex. Plan D: 100%/80%), the copay options, and whether the plan requires election of a primary care physician.

PPO Plans:
Plan B: _____ Physician Copay: _____ Hospital Copay: _____ PCP Election: _____
Plan C: _____ Physician Copay: _____ Hospital Copay: _____ PCP Election: _____
Plan D: _____ Physician Copay: _____ Hospital Copay: _____ PCP Election: _____
Plan E: _____ Physician Copay: _____ Hospital Copay: _____ PCP Election: _____
POS Plans:
Plan C: _____ Physician Copay: _____ Hospital Copay: _____ PCP Election: _____
Plan D: _____ Physician Copay: _____ Hospital Copay: _____ PCP Election: _____
Plan E: _____ Physician Copay: _____ Hospital Copay: _____ PCP Election: _____

Attach copies of the schedule page for each of the PPO and POS plan options indicated above.

(4) Do the plans provide for direct payment to health care practitioners without assignment? (Note: This option is available only on health service corporation plans and other plans offered in conjunction with selective contracting arrangements.)

_____ Yes _____ No

(5) Do the plans include any of the following as set forth by the IHC Board?

Centers of Excellence Features _____ Yes _____ No
Child(ren) Only Coverage _____ Yes _____ No
Care Manager Provisions _____ Yes _____ No
High Deductible Options _____ Yes _____ No

If yes: check the Plans and individual deductibles:

_____ Plan C: _____ $1500 _____$2250
_____ Plan D: _____ $1500 _____$2250

(6) How are Autologous Bone Marrow Transplants offered?
_____ in the policy
_____ mandated offer rider
(7) For POS Plans, how often may a female covered person use the services of a network gynecologist for non-surgical care without referral?
____ once per year
____ unlimited

(b) HMO Plan

(1) Check the copayment options being offered.
_____ $10 (Optional)
_____ $15 (Mandatory)
_____ $20 (Optional)
_____ $30 (Optional)

(2) How is prescription drug coverage being provided?
_____ subject to $15 Copayment
_____ subject to 50% Co-Insurance
(3) How are Autologous Bone Marrow Transplants offered?
_____ in the contract
_____ mandated offer rider
(4) Do the plans include any of the following as set forth by the IHC Board?
Child(ren) Only Coverage _____ Yes _____ No
Care Manager Provisions _____ Yes _____ No

(c)Compliance with Forms Changes

If this Certification is being submitted within one year of the effective date of forms changes, please complete the following:
Has the issue system been updated to reflect the changes to the policy forms which were effective during the prior year such that new plans issued on or after the effective date of the changes reflect all of the policy forms changes which were effective during the prior year ? _____ Yes _____ No
How are inforce policies/contracts being updated to reflect the policy forms changes which were effective during the prior year?
_____ reissue policies/contracts
_____ riders mailed to policyholders/contractholders *

* NOTE: The rider option may **only** be used if the IHC Board stated that the compliance and variability rider would be an appropriate mechanism to update inforce plans. If the rider is permitted to be used and this option is selected, the text of the rider must be identical to the text provided by the IHC Board.

4. CERTIFICATION

I, the undersigned, certify that this completed form is true and accurate and that I am an officer of the carrier duly authorized to submit this certification.

_____ _____

Date Signature

_____

Printed Name

_____

Title